APPEAL NO. 111821
FILED FEBRUARY 2, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on October 31, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the respondent (claimant) reached maximum medical improvement (MMI) on November 13, 2010; and (2) the claimant's impairment rating (IR) is 44%. The appellant (carrier) appeals the hearing officer's determinations on MMI and IR. The appeal file does not contain a response from the claimant.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], and that the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed Dr. M as the designated doctor to determine MMI and IR. The hearing officer found that: (1) Dr. M certified that the claimant reached MMI on November 13, 2010, with an assigned IR of 44%; (2) the preponderance of the evidence is not contrary to Dr. M's certification of MMI and IR; and (3) Dr. M performed an IR evaluation in accordance with the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides). There were several certifications of MMI and IR in evidence at the CCH by the designated doctor, Dr. M; by a doctor selected to act in place of the treating doctor, Dr. H; and by a post-designated doctor required medical examination doctor, Dr. S.

The claimant testified that she was injured at work on [date of injury], when she lost her balance carrying paperwork and fell backwards, with her right hand holding onto a door handle, and twisted herself and hit her head and back, falling to the ground with her right arm extended and left knee and leg under her.

The evidence reflected that there were two previous CCHs held on September 1, 2009, and October 7, 2010, respectively, regarding extent-of-injury conditions.

In Docket No. 1, the determination by the hearing officer that the compensable injury of [date of injury], extends to sprains and strains of the cervical spine, thoracic spine, lumbar spine and right shoulder and arm; head contusion; cervical and lumbar disc displacement, lumbar radiculitis, partial tear of rotator cuff of the right shoulder; and

tear of the medial meniscus and internal derangement of the left knee was not appealed and became final pursuant to Section 410.169.

In Docket No. 2, the determination by the hearing officer that the compensable injury of [date of injury], extends to reflex sympathetic dystrophy/complex regional pain syndrome (RSD/CRPS); cervical radiculopathy; headaches; and labyrinthitis was appealed to the Division's Appeals Panel but became final on December 17, 2010.

The hearing officer's determination that the claimant reached MMI on November 13, 2010, is supported by sufficient evidence and is affirmed.

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Division shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors.

28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)) provides in pertinent part that the assignment of an IR shall be based on the injured worker's condition as of the MMI date considering the medical record and the certifying examination and the doctor assigning the IR shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

(D) compare the results of the analysis with the impairment criteria and provide the following:

(i) [a] description and explanation of specific clinical findings related to each impairment, including [0%] [IRs]; and

(ii) [a] description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

The only certification of MMI and IR in evidence with the affirmed MMI date of November 13, 2010, is that of Dr. M, who examined the claimant on November 13, 2010, and who assigned a 44% IR. The evidence reflected that Dr. M was the only certifying doctor who rated the entire compensable injury as administratively determined in the prior CCHs when he examined the claimant on November 13, 2010.

Dr. M assigned 44% IR according to the AMA Guides based on the following: (1) for the spine - Dr. M assigned 15% whole person (WP) IR for Diagnosis-Related Estimate (DRE) Cervicothoracic Category III: Radiculopathy; 0% WP IR for DRE Thoracolumbar Category I: Complaints or Symptoms; and 5% WP IR for DRE Lumbosacral Category II: Minor Impairment. Dr. M then added 15% + 0% + 5% resulting in a 20% WP IR for the cervical, thoracic, and lumbar spine; (2) for the left knee - Dr. M assigned a 0% impairment for no range of motion (ROM) deficits for the left knee; (3) for labyrinthitis - Dr. M assigned a 15% WP IR for vestibular impairment under Section 9.1c Equilibrium, Class 3, page 9/229 of the AMA Guides; (4) for the right upper extremity (UE) and RSD/CRPS – 14% for ROM deficits combined with 18% UE for motor nerve deficit (radial), using Table 12 and Table 15, pages 3/49 and 3/54, respectively, resulting in 29% UE, which converts to 17% WP IR. Therefore, for the compensable injury, Dr. M combined 20% WP IR for the spine with 17% WP IR for right UE with 15% WP IR for vestibular impairment which results in 44% WP IR.

We first consider that Dr. M assigned 20% WP IR for the spinal injury. Dr. M failed to do an IR for the spine according to the AMA Guides as he attempted to add the impairments assigned for the cervical, thoracic, and lumbar spine. The AMA Guides provide that impairments for the cervical, thoracic, and/or lumbar spine are to be combined under the Combined Values Chart page 322 and not added. *See* page 3/101 of the AMA Guides under Section 3.3f Specific Procedures and Directions.

We next turn our attention to Dr. M placing the claimant in Class 3 under vestibular impairment. The AMA Guides, on page 9/229, provide:

> Class 3: Impairment of the [WP], 10% to 30%. A patient belongs in class 3 when (a) signs of vestibular dysequilibrium are present with supporting objective findings *and* (b) the patient's usual activities of daily living cannot be performed without assistance, except for such simple activities as self-care, some household duties, walking, and riding in a motor vehicle operated by another person.

In Dr. M's narrative report dated November 13, 2010, Dr. M does not list what specific records and testing related to the claimant's hearing or examination of the ears he reviewed for the purposes of determining MMI and IR or what specific activities of daily living cannot be performed without assistance.

In evidence is a report dated July 12, 2010, from Dr. Z, a referral doctor. Dr. Z stated that an "[o]toscope did show the eardrum appeared to be intact, bilaterally." Under impressions and recommendation, Dr. Z stated that there was "[n]ormal to borderline normal hearing for the left ear and no worse than a mild hearing loss for the right ear . . . . Normal middle ear function for both ears . . . . Normal auditory Brain

Stem responses for both ears . . . ." Also in evidence is a radiology report dated July 19, 2010, from Dr. Me, in which the impressions listed that there were no paranasal sinusitis and middle ears clear.

Also in evidence is a functional assessment dated February 9, 2010, listing her treating physician as Dr. W, which stated that the claimant is currently lifting 25 pounds and the claimant reports she can now do the following which she could not do before starting chronic pain management:

> Leaving her home, without assistance, daily….
>
> Take the dogs outside to go to the bathroom.
>
> Petting her dogs.
>
> Pulling on her socks and shoes.
>
> Dressing herself, without assistance, except for pulling a shirt overhead.
>
> Folding laundry.
>
> Get in and out of the car without assistance.
>
> Go to the grocery store for a longer period of time . . . now she can walk through a grocery store for an hour when needed.
>
> Unload and put away the groceries at home.
>
> Can open the microwave above her head and put in a cup of water for tea.
>
> She can wash her body in the shower without assistance.
>
> Sit in a restaurant and eat her entire lunch.

Additionally, in a report dated December 9, 2010, Dr. W, her treating doctor, stated that "[the claimant] is going to school for sociology and paralegal. She is using Dragon [we note this is voice recognition software] instead of doing data entry with her hands."

It is unknown from Dr. M's narrative report whether he reviewed these documents regarding the claimant's activities of daily living as well as testing and medical reports on her ears and hearing as discussed in the above paragraphs.

Under Rule 130.1(c)(3), Dr. M is required to provide description and explanation of specific clinical findings related to each impairment and is required to provide a description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. Dr. M failed to meet the requirements of Rule 130.1(c)(3) regarding his 15% IR assigned for the claimant's vestibular impairment by not documenting what clinical or objective findings would support the placement of claimant in Class 3 of vestibular impairment other than his conclusory statement that she meets the criteria of this class.

We next regard the right UE impairment assigned by Dr. M. The AMA Guides provide the steps necessary to rate Causalgia and RSD for the UE on page 3/56. Step one is to rate the UE impairment due to loss of motion of each joint involved (Sections 3.1f through 3.1j). Dr. M measured and assigned a 14% UE impairment for the loss of ROM for the right shoulder. Step two is to rate the sensory deficit or pain impairment according to instructions in this section and Table 11a (page 3/48). Dr. M did not document that he followed this second step. Step three is to rate the motor deficit impairment of the injured peripheral nerve, if it applies (Table 12a, page 3/49). Dr. M identified the radial nerve as injured and stated this would correlate with 35% (due to motor deficit of radial, elbow with sparing of triceps under Table 15, page 3/54) which is multiplied by the grade according to Table 12, page 3/49. But Dr. M's report contains inconsistencies as to what grade of motor deficit is shown by his exam. In one section of his report, Dr. M documented physical findings of a grade 4 motor deficit (under Table 12 is a 1-25%), and in his explanation of his IR stated the claimant had a grade 2 (under Table 12 is a 51-75%) but assigned 50% (which under Table 12 is a grade 3 motor deficit). Dr. M, in spite of his inconsistencies, calculated 35% x 50% which results in 17.5% which he rounds up to 18% UE impairment. Dr. M did not perform his UE IR according to the criteria of the AMA Guides.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

Consequently, the hearing officer's finding that Dr. M performed an IR evaluation in accordance with the AMA Guides and that portion of the hearing officer's finding that the preponderance of the evidence is not contrary to Dr. M's assigned IR is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. There is no other certification of MMI and IR with the affirmed MMI date of November 13, 2010, or assigned IR for the entire compensable injury.

Therefore, we reverse the hearing officer's determination that the claimant's IR is 44% and remand the IR issue to the hearing officer.

REMAND INSTRUCTIONS

Dr. M is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. M is still qualified and available to be the designated doctor. If Dr. M is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed pursuant to Rule 127.5(c) to determine the claimant's IR for the compensable injury. The hearing officer is to: (1) advise the designated doctor that the claimant reached MMI on November 13, 2010; (2) advise the designated doctor that the compensable injury of [date of injury], extends to sprains and strains of the cervical spine, thoracic spine, lumbar spine and right shoulder and arm; cervical and lumbar disc displacement; lumbar radiculitis; cervical radiculopathy; partial tear of rotator cuff of the right shoulder; RSD/CRPS; head contusion; headaches; labyrinthitis; and tear of the medial meniscus and internal derangement of the left knee; and (3) to provide an IR based on the claimant's condition as of the MMI date considering the medical record (which is to include any medical reports and testing of the ears and the claimant's hearing for the years 2010 through the date of the CCH, as well as functional assessments and records of the claimant's retraining and schooling) and the certifying examination and in accordance with the AMA Guides and Rule 130.1(c)(3).

The parties are to be provided with the hearing officer's letter to the designated doctor and the designated doctor's response. The parties are to be allowed an opportunity to respond.

SUMMARY

We affirm the hearing officer's decision that the claimant reached MMI on November 13, 2010.

We reverse the hearing officer's determination that the claimant's IR is 44% and remand the IR issue to the hearing officer.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section

662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* Appeals Panel Decision 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **NEW HAMPSHIRE INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3232.

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge